IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
EASTERN DIVISION

JOHN E. MULLIN, Plaintiff, vs. JO ANNE B. BARNHART, Commissioner of Social Security, Defendant.	No. C03-1028 **ORDER**

This matter comes before the court pursuant to briefs on the merits of this application for disability insurance benefits. The parties have consented to the exercise of jurisdiction by a United States Magistrate Judge pursuant to 28 U.S.C. § 636(c). The court finds in favor of the defendant and the matter is dismissed.

Procedural Background

Plaintiff John Mullin applied for Title II and Title XVIII Social Security benefits on November 14, 2000 alleging an inability to work since November 6, 2000 due to HIV/AIDS, CMV, asthma, allergies, nausea, diarrhea, wasting and fatigue. His application was denied and denied again on reconsideration. A hearing before Administrative Law Judge (ALJ) Andrew T. Palestini was held on February 14, 2002. In an opinion dated August 29, 2002, the ALJ denied benefits. On July 17, 2003, the Appeals Council denied the plaintiff's request for review. This action for judicial review was timely filed on September 17, 2003.

Factual Background

The plaintiff was born on October 8, 1973. (Tr. 65). He has a high school education with one year of completed college courses in telecommunications. (Tr. 92). He has past relevant work experience as a telephone sales/marketing representative. (Tr. 147).

Between the period of December 1997 and January 1999, the plaintiff was seen by Dr. Richard Mahr and various attending doctors in the Health Partners' Urgent Care Center for asthma exacerbation, recurring bronchitis, and sinusitis. (Tr. 158-61, 164-67). In each of these visits, the doctors advised the plaintiff to stop smoking. (Tr. 158-61, 164-67). A prescription for Zyban was given on September 25, 1998 for that purpose. (Tr. 160-61). The plaintiff was also consistently prescribed an antibiotic for bronchitis and sinusitis and instructed to continue taking Albuterol in conjunction with an inhaler. (Tr. 158-61, 164-167).

On August 20, 1998, the plaintiff was seen by Dr. Cyril Kapsner, a physician at Health Partners, for episodes of dizziness, lightheadedness, shortness of breath, tingling in his hands, and a fast heart rate. (Tr. 162-63). Dr. Kapsner observed that the plaintiff appeared normal during the examination and instructed the plaintiff to monitor his symptoms and follow-up in the clinic if the dizziness returned or new symptoms emerged. (Tr. 162-63). No such follow-up is documented in the record.

In late 1998, the plaintiff was diagnosed as HIV positive. (Tr. 155). The plaintiff notified Dr. Mahr of this on December 9, 1998 by telephone. (Tr. 155). The plaintiff agreed to get background testing done with Dr. Mahr while he waited for his initial infectious disease appointment at the end of January. (Tr. 155). Dr. Mahr observed that the plaintiff was "understandably distraught," but that he denied suicidal thoughts. (Tr. 155). On December 17, 1998, the HIV background testing indicated that the plaintiff was in fact HIV positive, however, he was "not a high risk for an imminent AIDS defining

illness" at that time. (Tr. 151-52). The plaintiff's weight at that time was 273 pounds. (Tr. 151).

The plaintiff also spoke with Dr. Bonnie Mulligan of the Behavioral Health Department of Health Partners on December 17, 1998. (Tr. 153-54). The plaintiff reported that he had been crying a lot since his diagnosis, but he was finally beginning to process the information, especially after getting positive medical news that day. (Tr. 153). The plaintiff also discussed mapping out the next few years of his life and how to tell his co-workers and mother about being HIV positive. (Tr. 153). On January 5, 1999, the plaintiff had a follow-up appointment with Dr. Mulligan. (Tr. 234-35). During this appointment, the plaintiff reported having trouble sleeping, having bad dreams, "mov[ing] from feeling depressed and doing nothing to being very active and positive," and "periods of being very angry." (Tr. 234). The plaintiff also indicated that he had recently made his third attempt to return to work and that previous attempts were unsuccessful because he missed work due to illness. (Tr. 234). The plaintiff asked Dr. Mulligan to complete paperwork that would allow him to use the Family Medical Leave Act for future needs to be off work. (Tr. 234). Dr. Mulligan's diagnosis following this appointment was post traumatic stress disorder, as well as some signs of depression. (Tr. 235).

In January of 1999, Dr. Mahr indicated that a September 1995 episode of scabies was suspicious for primary HIV infection. (Tr. 233). Upon discussion of this history with Dr. Mahr, the plaintiff indicated that he too suspected his primary HIV infection was in late 1995. (Tr. 226).

On January 20, 1999, the plaintiff was again seen by Dr. Mulligan. (Tr. 229-30). The plaintiff reported that he quit smoking and that he "wants to do everything he can to remain healthy." (Tr. 229). He also described problems he was having with getting short term disability pay under the Family Medical Leave Act from his employer and that as a result he was having financial difficulties. (Tr. 229-30). The plaintiff indicated that he was seeking legal assistance for these issues. (Tr. 229-30). Dr. Mulligan maintained her

diagnosis of post traumatic stress disorder and added the diagnosis of adjustment disorder with anxiety and depression. (Tr. 230).

The plaintiff was seen by Dr. Mahr on January 22, 1999 for general concern about his health and sleep disturbances. (Tr. 226). Dr. Mahr described the plaintiff as having a "fairly positive outlook" although he appeared tired and was tearful at times during the appointment. (Tr. 226, 228). Dr. Mahr determined that the plaintiff's sleep disturbance was caused by several factors including medication and stress. (Tr. 228). Subsequently, in a letter dated January 25, 1999, Dr. Mahr wrote the plaintiff's employer, US West, stating, "[I]t is in the best interest of his physical and mental health at this time that he be allowed flexibility with working overtime and that he avoid mandatory overtime if he does not feel up to it." (Tr. 227).

On January 28, 1999, the plaintiff had his first appointment with Dr. David Strike of Health Partners' Infectious Disease Department. (Tr. 225). During this initial consultation, Dr. Strike spoke with the plaintiff generally about management of his life and health with HIV. (Tr. 225). He noted the plaintiff's "significant depressive symptoms over the past couple of months" and indicated that he would like the plaintiff to continue working with the psychology department to improve the situation and to reduce his antidepressive medications. (Tr. 225). In addition, Dr. Strike observed, "it is of some interest that the patient has had upper respiratory problems over the past few months. This may affect his [CD4 and viral load] counts." (Tr. 225).

On February 19, 1999, the plaintiff was seen by Dr. Mahr for general health counseling, including discussions about his medication care plan, tobacco use, depressive symptoms, and HIV disease. (Tr. 222-24). Dr. Mahr commented that the plaintiff was still not smoking and had successfully lost 16 pounds on the Atkins diet. (Tr. 222-23). He also noted that the plaintiff's sleep disturbances improved with use of Temazepam and that "he looks well, [is] in good spirits, clearly happier than other recent visits, [and] more upbeat." (Tr. 223). Dr. Mahr did not do a further physical examination at this appointment. (Tr. 223).

On March 10, 1999, Dr. Strike discussed with the plaintiff his recent CD4 count, which was down to 163 and 19% from 364 and 37%. (Tr. 221). Dr. Strike listed three possible factors that could cause a patient's CD4 count to go down artificially: stress, alcohol, and an ongoing infection. (Tr. 221). The plaintiff indicated that he had all three factors. (Tr. 221).

On March 17, 1999, the plaintiff was seen by Dr. Mulligan. (Tr. 219-20). The plaintiff expressed concern for his low CD4 count and reported that although his count had gone up slightly, he was physically ill and unable to go to work. (Tr. 219). He described himself as feeling depressed and crying easily, and stated that he "doesn't know who he is." (Tr. 219). Dr. Mulligan "noticed that he had smelled of liquor when he came in" and discussed alcohol use with the plaintiff. (Tr. 219). He admitted to drinking in excess and stated that alcohol gives him "momentary relief from his problems." (Tr. 219). He also revealed that he drank in a binge pattern during college. (Tr. 219). Dr. Mulligan noted that the plaintiff was aware of the negative effects of his drinking in excess, especially when considering his medical condition and the effect of alcohol on the liver. (Tr. 219). The plaintiff indicated that he believed he could keep his drinking under control. (Tr. 219).

The plaintiff was seen in late March of 1999 by Dr. Mahr and Dr. Mulligan. During these two appointments, the plaintiff's absences from work in conjunction with his recent HIV diagnosis, sleep disturbances, and depressive issues were discussed. (Tr. 218, 216-17). Dr. Mahr noted that the plaintiff's recurrent respiratory problems also contributed to his absences from work. (Tr. 218). However, Dr. Mahr also stated, "I encouraged [the plaintiff] to try to attend work even if he wasn't feeling particularly well. If he could do it that, from the standpoint of his degree of functioning physically and socially, I think would be to his advantage to spend more time at work." (Tr. 218). Dr. Mulligan discussed setting up parameters for missing work with the plaintiff, especially since he was still experiencing difficulty receiving short term disability under the Family Medical Leave Act. (Tr. 216). The plaintiff developed a plan to miss work

only "when he was crying and didn't want to embarrass himself." (Tr. 216). Additionally, the plaintiff reported that he had a new intimate relationship, which had been going well for the last two to three weeks. (Tr. 216). Dr. Mulligan commented that "he seemed in a good mood today, but he does seem to swing between feeling fine and feeling very depressed." (Tr. 217). She maintained her diagnosis of adjustment disorder with depressed mood at the end of the appointment. (Tr. 216).

On April 1, 1999, Dr. Mahr treated the plaintiff for recurrent respiratory infection symptoms, which had returned following a successful treatment in March. (Tr. 213-15). In addition to post nasal drainage, bleeding gums, and some whitish plaques or patches, the plaintiff believed he had thrush. (Tr. 213). Dr. Mahr prescribed an antibiotic for the respiratory infection and a Nystatin Swish and Swallow for possible thrush. (Tr. 214). Additionally, the plaintiff complained of continued sleep disturbances and recurrences of sweats over the last couple of months. (Tr. 213-14). Dr. Mahr renewed the plaintiff's Restoril prescription. (Tr. 213-14). The plaintiff's weight at this appointment was 245. (Tr. 213).

On April 14, 1999, the plaintiff was seen by Dr. Mulligan. (Tr. 209). The plaintiff reported experiencing some chronic fatigue, hot flashes, and sweats. (Tr. 209). He was concerned that he had a difficult time making it through nine holes of golf with his brother a few days earlier; he was also afraid of getting sick because he was not yet taking antiretroviral medication. (Tr. 209). The plaintiff further stated that he was having a hard time separating out the physical and emotional issues he was experiencing, including high levels of stress and anxiety. (Tr 209). The plaintiff articulated concerns about work in regards to his customers, his income through commission, and getting short term disability approved. (Tr. 209). In response to Dr. Mulligan's inquiry about what he can do to help his depression, the plaintiff expressed a desire to restart his photography hobby. (Tr. 210). In a follow-up appointment with Dr. Mulligan on May 4, 1999, the plaintiff reported feeling better physically, that he had followed through with his photography plans, and that he was attending work regularly with only one absence in the last month.

(Tr. 207). He also related that work was continuing to question his short term disability and this was causing him anxiety and stress. (Tr. 207). For these symptoms, he reported taking some Xanax he received from his partner. (Tr. 207). Dr. Mulligan told him that taking medication not prescribed to him is inappropriate and that she would like to see him work relaxation techniques into his stress management instead of additional medication. (Tr. 207).

On May 19, 1999, the plaintiff was seen by Dr. Strike for an HIV follow-up appointment. (Tr. 204). Dr. Strike noted that the plaintiff's "overall condition continues to improve." (Tr. 204). The plaintiff's weight was 244 and his CD4 count rose from 19% to 36% between February and April. (Tr. 204). The plaintiff announced that he was working again full time and was enjoying it, however, he was still having problems receiving short term disability benefits. (Tr. 204). The plaintiff asked Dr. Strike to write a letter to Joan K. Boley in Health Services at US West to further explain the severity of his condition. (Tr. 204). In a letter dated May 19, 1999, he stated:

> Between 12/10 and 2/23/99 [Mr. Mullin's] CD4 count dropped from 364 to 163 with only 19% of lymphocytes showing CD4 markers. This would clearly put him in the immune deficient and AIDS category temporarily. . . . The reason for this apparent deterioration in immune function most likely was his severe stress reaction complicated by recurring sinusitis and oral thrush. By mid March the CD4 count was improving and was up to 264 and in early April his CD4 count had risen to 339 and 36%. I expect this improvement was coincident with controlling his sinus infection and successfully managing his stress reaction. Shortly thereafter the patient reports that he was able to resume working full time.
>
> I think there is little doubt that this patient experienced significant illness that was measurable in terms of psychological functioning and also objectively measurable by immune parameters. I have no doubt whatsoever that he was disabled in terms of being unable to perform his job in anything other than a very part time capacity at that time.

(Tr. 207-06). Dr. Strike further indicated that once the plaintiff started antiretroviral medications, "there may be some temporary stress related to beginning medications but I expect that he will be able to adjust in a short period of time and continue to function well at his job." (Tr. 206).

On May 21, 1999, the plaintiff was seen by Dr. Mahr for basic medical follow-up. (Tr 200). Dr. Mahr noted that the plaintiff was successfully treated for chronic sinus symptoms with Amoxicillin recently. (Tr. 200). He also noted that the plaintiff was still experiencing problems at work and had intermittent episodes of anxiety, although he was not distressed while at the appointment. (Tr. 200). Upon physical examination of the plaintiff, Dr. Mahr found that everything was normal, except for a mild erythematous rash on his upper arms. (Tr. 200).

The plaintiff began to experience chronic respiratory problems again and was seen on June 1, 1999, by Dr. Ovidiu Ardeleanu. (Tr. 198-99). It was determined that the plaintiff had either bronchitis or pneumonia with dehydration and the plaintiff was given Bactrim DS and Erythromycin prescriptions. (Tr. 198-99). Additionally, on June 14, 1999, Dr. Mahr referred the plaintiff for a CT scan of his sinuses. (Tr. 197). On June 16, 1999, the plaintiff was seen by Dr. Mulligan, who reports that the plaintiff was feeling better but still suffering from a sinus infection. (Tr. 194-95). The plaintiff also reported to her that he was continuing to have difficulty sleeping, but was not missing work unless he was ill. (Tr. 194-95).

On June 23, 1999, the plaintiff had a routine follow up with Dr. Strike. (Tr. 193). At this time, his weight was 243, his CD4 was 167 and 22%, and his viral load was 22,000. (Tr. 193) Both the plaintiff and Dr. Strike agreed it was time to start antiretroviral medication. (Tr. 193). Dr. Strike also noted that the plaintiff continued to have problems at work and that his employer no longer wanted him to work full time "for some reason." (Tr. 193). On June 30, 1999, the plaintiff saw Dr. Strike and discussed his issues at work. (Tr. 190). Dr. Strike noted that he believed that "the patient's request for accommodation at work. . .seem[ed] extraordinarily simple" and that he would

"continue to try to cooperate with the patient and provide him the support" he needs. (Tr. 190.) Dr. Strike also determined that the plaintiff's "stress level remains too high relative to all these issues for him to begin antiretroviral therapy" and delayed the start date until work issues were resolved. (Tr. 190).

Between June 29, 1999 and July 15, 1999, the plaintiff was seen by an attending physician in the Urgent Care Center, by Dr. Mahr, and by Dr. H. W. Park of Summit/Landmark Orthopedics, LTD., for shoulder pain after he fell from a golf cart. (Tr. 191-92, 187, 185-86, 178, 171-75). Dr. Park made the final assessment and determined that the plaintiff had a moderate neck strain, a Grade II AC joint sprain, and a left shoulder rotator cuff contusion and sprain. (Tr. 172). He recommended symptomatic treatment with early range of motion exercises and pain medication over the first few days. (Tr. 172). The plaintiff was to follow-up and begin physical therapy for his shoulder in three weeks. (Tr. 172).

In August of 1999, the plaintiff was seen twice by Dr. Mulligan to discuss work issues. (Tr. 183-84, 181-82). At the first appointment, he indicated that he had been suspended and he expressed sadness about his employer's decision, but he also reported that he had already begun looking for a new job. (Tr. 183-84). At the second appointment, the plaintiff announced that he had been terminated from work. (Tr. 181). He stated that although he felt badly, he thought that "it may be for the best" and that a job interview with a communication company was already set up. (Tr. 181). The plaintiff also discussed the fluctuations in his CD4 counts, which he believed were directly related to stress. (Tr. 181-182).

On August 25, 1999, the plaintiff saw Dr. Strike regarding his new CD4 count: 370 and 25%. (Tr. 180). At this appointment, both Dr. Strike and the plaintiff agreed that it was time for the plaintiff to begin antiretroviral medications. (Tr. 180). Dr. Strike decided to put the plaintiff on D4T, 3TC, Crixian and Ritonavir. (Tr. 180). Other drugs were avoided because of the plaintiff's occasional alcohol use. (Tr. 180).

Between September 15, 1999 and November 3, 1999, the plaintiff was seen by Dr. Strike for medication and general HIV follow-up appointments. On September 15,1999, Dr. Strike noted that the plaintiff had initial nausea and vomiting with Ritonavir, but it had settled down. (Tr. 179-80). On November 3, 1999, Dr. Strike indicated that while the plaintiff was doing quite well generally, he did have daily diarrhea. (Tr. 177). The plaintiff reported that taking Imodium pills with his medication seemed to help. (Tr. 177). Dr. Strike also noted that the plaintiff had gained 23 pounds since August, for a current weight of 274, and that he planned to start a new low-carbohydrate diet. (Tr. 177). The plaintiff also reported that he separated from his domestic partner and "now [he] is living alone and feeling quite a bit happier." (Tr. 177).

On December 13, 1999, the plaintiff's CD4 count was 482 and 41%, the plaintiff's best to date, and his viral load was undetectable at less than 50. (Tr. 176). Dr. Strike noted that the plaintiff's sinusitis symptoms had improved and he had lost five pounds through dieting with a current weight of 269. (Tr. 176).

After an appointment on February 8, 2000, Dr. Strike made a general assessment of the plaintiff's fluctuating CD4 and viral load counts since he began medications in August of 1999. (Tr. 292). He stated:

> [Mr. Mullin's] initial viral load was relatively load [sic], but he had significant suppression of his CD4 count in the 100 to 200 range. For that reason he was begun on a drug. He has responded well with his viral load going to undetectable, but his CD4 count has rebounded relatively little. He now is in the 40% and 4 to 500 range. The patient was first exposed to HIV in approximately 1994, so he has had a fairly significant alteration of his CD4 count in the face of a fairly low viral load over a fairly short period of time, and he is atypical in this respect.

(Tr. 292).

On March 27, 2000, the plaintiff reported continuing dry lips and skin and "significant diarrhea from his HIV medications." (Tr. 291). Dr. Strike adjusted the plaintiff's medication by reducing the Ritonavir and increasing the Crixivan. (Tr. 291).

Additionally, Dr. Strike reported that the plaintiff's "viral load has remained undetectable with early, rapid response." (Tr. 291). He also noted that the plaintiff's cholesterol was elevated and there was "evidence of positive CMV serology." (Tr. 291). Dr. Strike and the plaintiff agreed that he should eliminate saturated fats to lower his cholesterol. (Tr. 291). Hepatitis C tests were also ordered for the plaintiff. (Tr. 291).

On April 13, 2000, the plaintiff was again seen by Dr. Strike. (Tr. 287). This appointment was dedicated primarily to the plaintiff's complaints of sinusitis symptoms and sleep disturbances. (Tr. 287). Considering the plaintiff's history of sinus problems, Dr. Strike prescribed an antibiotic although he doubted that the plaintiff had bacterial sinusitis at that point. (Tr. 287). Dr. Strike also prescribed a sleep aid with no refills for his sleep disturbances. (Tr. 287). He indicated to the plaintiff that it would be more beneficial for him to alter his sleeping habits instead of relying on medications. (Tr. 287). Dr. Strike noted that he considered the plaintiff to be high risk for problems with drug habituation and/or dependency. (Tr. 287).

On July 26, 2000, the plaintiff reported experiencing nausea and occasional vomiting and had lost weight although he was not trying to do so. (Tr. 289). The plaintiff also reported that he was now working. (Tr. 289). Dr. Strike noted that the "diarrhea and nausea actually improved significantly after his last visit after he modified his dose of Ritonavir and Crixivan." (Tr. 289). The plaintiff's CD4 count was 386 and his viral load remained at less than 50. (Tr. 289). Dr. Strike also noted that the plaintiff was alert and had no apparent distress upon physical examination except for a red throat which is "consistent with smoker's throat." (Tr. 289).

On August 3, 2000, the plaintiff was seen at St. John's Hospital-Northeast by emergency physician Dr. Terrence Brayboy for a headache, nausea, vomiting, and diarrhea. (Tr. 256-58). Dr. Brayboy determined that the plaintiff's symptoms "appeared to be related to his HIV medications." (Tr. 257) The plaintiff was given one liter of normal saline and instructed to drink plenty of fluids at home and to follow-up with his family doctor as needed. (Tr. 258).

On August 7, 2000, the plaintiff followed-up with Dr. Mahr. (Tr. 284). The plaintiff continued to complain of the symptoms he reported to Dr. Brayboy as well as recurring sleep disturbance and chronic soreness in his stomach. (Tr. 284). The plaintiff reported that he quit his job and cashed in a life insurance policy and stocks to remedy his consequential financial problems. (Tr. 284). Additionally, the plaintiff related that he had "found himself holding his handgun the other day for a minute. . .thinking about shooting himself, [but] he decided he wished to live." (Tr. 284). After determining that the plaintiff was not currently suicidal, Dr. Mahr noted, "[W]hile I think his medications are contributing to chronic physical symptoms, I do also think he is getting depressed and needs to acknowledge that. He does seem to acknowledge it and he will contact Mental Health for an intake appointment." (Tr. 284). He also stated that the plaintiff's sleep disturbances were tied in with his depression, which should be controlled by behavior and not medication. (Tr. 284). The plaintiff's weight was 244. (Tr. 284).

On September 8, 2000, the plaintiff was seen by Dr. Mahr primarily for follow-up regarding his stomach and respiratory problems. (Tr. 281-82). Dr. Mahr noted that the plaintiff's gallbladder ultrasound came back normal and that his upset stomach improved with medication. (Tr. 281, 287). Dr. Mahr also noted, however, that the plaintiff's respiratory issues were worsening again. (Tr. 281). The plaintiff's stomach problems would continue to be regulated through medication and he was given an Albuterol nebulizer treatment and prescribed two new types of inhalers for his respiratory issues. (Tr. 282). The plaintiff also reported that he had taken two jobs, but had not seen a psychiatrist since his last appointment. (Tr. 281). He stated that "he is too busy in his life to see a psychiatrist and does not feel that he needs ongoing therapy." (Tr. 281). The plaintiff did agree to see a psychiatrist for one or two appointments at the end of his appointment with Dr. Mahr. (Tr. 283).

On September 11, 2000, the plaintiff was seen for the last time by Dr. Strike. (Tr. 279). The plaintiff reported that the stomach problems he expressed to Dr. Mahr have "improved dramatically" with medications and his respiratory system was "somewhat

better although he is not yet back to normal." (Tr. 279). Dr. Strike noted that the plaintiff's weight was 235 and he "remains in full viral remission on [medication]." (Tr. 279). Dr. Strike and the plaintiff also discussed seeing a psychiatrist. (Tr. 279). Dr. Strike noted that although the plaintiff has "never been overtly suicidal," he did state that when he was sick he "would rather be dead." (Tr. 279). Dr. Strike "strongly encouraged him to follow through now that he is doing well and to establish a relationship with a psychiatrist so that this relationship it [sic] available to him should he have future crises."

On November 14, 2000, the plaintiff was seen by Dr. J. Bruce Abele of The Medical Associates Clinic to set up medical care in Iowa. Dr. Abele briefly reviewed the plaintiff's medical history and noted "a fair amount of diarrhea, some periodic wasting, some nausea" has accompanied the plaintiff's medication. (Tr. 263). However, Dr. Abele noted that "quite recently [the] patient has been getting on reasonably well." (Tr. 263). The plaintiff reported that he was feeling much better since changes in his antiviral regimen were made in response to his diarrhea problems. (Tr. 263). Upon physical examination the only abnormality was a slight nonspecific flat erythematous rash around the plaintiff's shoulders, upper arm and upper back. (Tr. 264, 262). The plaintiff seemed clinically stable. (Tr. 262). It was also noted that the plaintiff was currently smoking a little less than a pack a day of cigarettes and that he was urged to stop. (Tr. 264). On November, 20, 2000, the plaintiff was seen by Dr. Abele for a respiratory infection and was prescribed an antibiotic. (Tr. 261).

On November 24, 2000, Dr. Strike completed the "Physician's Report on Adult With Allegation of Human Immunodeficiency Virus (HIV) Infection" provided by the Department of Health and Human Services Social Security Administration. (Tr. 276-77). In this report Dr. Strike summarized that while the plaintiff was in fact HIV positive, he had no opportunistic or indicator diseases present, nor did he have any other manifestations of HIV infection persisting over a two-month period at that time. (Tr. 276-77). Dr. Strike determined that the plaintiff's functional limitations were as follows: mild restrictions on

daily living activities; mild to moderate difficulties in maintaining social functioning; mild to moderate difficulties in completing tasks in a timely manner due to deficiencies in concentration, persistence or pace; moderate repeated episodes of deterioration or decompensation (averaging three times a year or once every four months, lasting two or more weeks each) in work or work-like settings. (Tr. 277). Dr. Strike also hand wrote a comment on the report, "pt has experienced recurring sinusitis, asthma, significant depression with associated weight loss; has lost 14% of body weight." (Tr. 277).

On December 13, 2000, Dr. Strike also drafted a letter in support of the plaintiff's application for disability. Dr. Strike briefly summarized the fluctuations in the plaintiff's CD4 and viral load counts and the multiple complications of his health management while under his care, noting that some of his problems predated his HIV diagnosis. (Tr. 274). Dr. Strike then stated:

> All things considered, his management has been quite difficult and I expect it will remain so for the foreseeable future. Mr. Mullin has attempted to work at several jobs over the past couple of years but has been unable to manage the stress of full time employment. . . . I expect that Mr. Mullin's overall situation meets the condition of disability related to medical problems. . . . With regard to his work related capacities, I think he has normal capacity for seeing and hearing and speaking. He has no musculoskeletal abnormalities that would preclude stooping, climbing, kneeling and walking but he is troubled by significant fatigue and some weakness due to weight loss. His frequent medical problems have necessitated multiple visits to physicians and the problems, as well as the time requirements for medical care, have limited his ability to maintain full-time employment.

(Tr. 274-75).

On November 28, 2000, the plaintiff was seen by Dr. John P. Viner of the Infectious Disease Department of Dubuque Internal Medicine. (Tr. 265-68) Dr. Viner described the plaintiff as a "fit-appearing man" whose "weight is on the high side for his frame at 231 pounds." (Tr. 266). Upon physical examination, Dr. Viner determined that most everything was normal or at least unremarkable, except for a mild rash, tender, but

not pathologically enlarged nodes, and a "bit touchy" sigmoid colon. (Tr. 265-68). The plaintiff complained of chronic heartburn and upper abdominal problems as well and Dr. Viner indicated that an endoscopy may be needed for further diagnosis as the plaintiff was "attributing many of the abdominal symptoms to antiretroviral therapy which may not be correct." (Tr. 266). Lab results for tests ran at the appointment came back on November 29, 2000, which showed that the plaintiff's CD4 count was 448 and 41%. (Tr. 375).

On January 30, 2001, the plaintiff had a follow-up appointment with Dr. Viner. (Tr. 347). The plaintiff reported vomiting, heartburn, reflux symptoms, respiratory issues, diarrhea, hot and cold spells, and night sweats on occasion, however, he also indicated that his "stomach feels somewhat better" now. (Tr. 347). Upon examination, Dr. Viner determined that everything was either normal or unremarkable. (Tr. 348). Dr. Viner also noted that the plaintiff's viral load was "very satisfactory with the Ultra Sensitive measurement being below detection" and his CD4 showed improvement up to 448. (Tr. 347). The plaintiff's weight was 239 at this appointment. (Tr. 248).

On February 1, 2001, Dr. Mahr wrote a letter to Lori Deason, the disability examiner for the State of Iowa explaining the cytomegalovirus (CMV) test and the plaintiff's results of that test. (Tr. 300). He stated, "[The test] is a routine testing in HIV patients and does not specifically identify a site of infection nor does it necessarily suggest any ongoing active infection at any particular body site. It is in this case an indication of prior exposure to the virus."(Tr. 300).

Between February 19, 2001 and March 5, 2001, the plaintiff was seen for respiratory problems, including nasal drainage, ear ache, coughing with sputum production, and nausea. (Tr. 347, 422, 343-45). Dr. Viner prescribed oseltamivir for these problems. (Tr. 347). On February 23, Dr. Federick Isaak, the attending physician in the Medical Associates Clinic Acute Care Center, ordered an x-ray of the plaintiff's chest. (Tr. 347). He noted that while the x-ray was otherwise normal, the plaintiff did have some milleri infiltrates present indicating the possibility of pneumocystis pneumonia

and prescribed Bactrim DS and Prednisone. (Tr. 422). On March 5, Dr. Viner determined that the plaintiff had dyspepsia and apparent reflux, respiratory infection and doubted that he had pneumocystis pneumonia. (Tr. 343). Dr. Viner noted that the plaintiff was feeling better with less coughing and sputum production and no recent diarrhea. (Tr. 343). The plaintiff's weight was 247 and his CD4 was 672. (Tr. 343).

On March 8, 2001, the plaintiff was seen by Dr. Darryl K. Mozena for right shoulder pain following a fall on some ice. (Tr. 341, 355). Dr. Mozena determined that an x-ray taken of the plaintiff's shoulder was normal and the pain was caused by a probable sprain; he prescribed pain medication for the plaintiff. (Tr. 341).

On March 23, 2001, Dr. Stephen Elliot completed a Physical Residual Functional Capacity Assessment for the plaintiff's impairments. (Tr. 305-14). He determined that the plaintiff is capable of lifting twenty pounds occasionally and ten pounds frequently, of standing, walking, and sitting for six hours in an eight-hour day, and of pushing or pulling without limitation. (Tr. 306). Dr. Elliot further determined that the plaintiff could occasionally climb, balance, stoop, kneel, crouch, and crawl. (Tr. 307). He also indicated that the plaintiff has no manipulative, visual, or communicative limitations. (Tr. 308-09). Dr. Elliot determined that the plaintiff should avoid concentrated exposure to extreme cold or heat, wetness, humidity, and fumes, odors, dusts, and gases, however exposure to noise, vibration, or hazards are unlimited. (Tr. 309). In his written comments, Dr. Elliot stated:

> The evidence in file is consistent with the allegation of HIV infections and a history of asthma. His asthma seems to be under excellent control and there is no evidence of organ system involvement or management complications requiring intensive interventions. The claimant's credibility is eroded in several significant areas. On the claimant's ADL's he states he has aching pains and sharp pains in his back and needs to take significant pain medicines including Percocet of [sic] Tylenol. At his most recent visits to his physicians in Iowa none of these are mentioned. At his most recent visits there is no mention of any pain medications and he takes Marinol primarily to help increase his weight and to decrease his

> anxiety. In fact at the last examination his weight is described as being on the high side for his frame. No specific abnormalities were described in these 2 complete exams. His generalized muscle stiffness was not found on his exam. His allegations are however credible to the extent that he would be limited as noted on the attached RFC.

(Tr. 314).

On March 27, 2001, Dr. George M. Harper of Counseling and Assessment Service, P.C. preformed an abbreviated psychological evaluation upon a referral by Lori Deason. (Tr. 301). Dr. Harper summarized his impressions of the plaintiff by stating:

> John Mullin was interviewed and revealed many symptoms of major depressive order. . . . At the present time Mr. Mullin is experiencing depressed mood, anhedonia, sleep and appetite difficulties, weight loss, feeling of hopelessness and worthlessness, some memory and concentration difficulties, frequent suicidal thinking (but no recent suicidal plans or attempts), as well as a history of panic attacks which continue up to the present time. . . . [T]he client does not report any significant perceptual problems nor does he exhibit any frank thought disorders. His depression renders him mildly disabled in regards to his ability to remember and understand instructions, procedures and locations, his ability to use good judgement and his capacity to focus and sustain his attention to tasks. On the other hand, the client reports moderate difficulty maintaining concentration and pace. He is capable of interacting appropriately with co-workers, supervisors, and the public, and probably experiences only mild difficulty, if any, in responding appropriately to changes in the work place. Should this client be found eligible to receive disability payments, he is capable of managing his funds.

(Tr. 303). Dr. Harper diagnosed the plaintiff with major depressive disorder, single episode, severe without psychotic features and panic disorder without agoraphobia. (Tr. 303).

On May 24, 2001, Dr. Viner completed the "Physician's Report on Adult With Allegation of Human Immunodeficiency Virus (HIV) Infection" provided by the Department of Health and Human Services Social Security Administration. (Tr. 380-84).

Dr. Viner indicated that the plaintiff was in fact HIV positive, but had no opportunist or indicator diseases present at that time. (Tr. 380-81). He listed other manifestation of HIV the plaintiff was experiencing as chronic diarrhea, daily four to six times for one year and night sweats and weakness, three or more times a year, with a two-week duration. (Tr. 382). Dr. Viner also hand wrote the following: "night sweats and hot/cold spells worsened when attempt was made to work." (Tr. 382).

On May 25, 2001, the plaintiff was seen by Dr. Mark O. Liaboe of Dubuque Internal Medicine. (Tr. 337). The plaintiff reported not feeling well for several days with a fever, sweats, and chills, as well as passing dark urine and some bilateral back and flank discomfort. (Tr. 337). Dr. Liaboe ran several tests, but no prescription was given that day. (Tr. 337). On May 31, 2001, Dr. Viner gave the plaintiff a prescription for Marinol. (Tr. 337).

On July 23, 2001, Dr. Sandra L. Davis completed a psychiatric review technique form and Residual Functional Capacity Assessment for the plaintiff. (Tr. 387-406). Dr. Davis indicated that the plaintiff's medical disposition was based upon the categories of affective disorders and anxiety-related disorders. (Tr. 387). Under the category of affective disorders, Dr. Davis indicated that the plaintiff exhibited a depressive syndrome characterized by anhedonia, appetite disturbance with change in weight, sleep disturbance, feelings of guilt or worthlessness, difficulty concentrating, thinking, and remembering, thoughts of suicide, and hallucinations which are medication-related. (Tr. 390, 405). Under the anxiety-related disorders, Dr. Davis stated that the plaintiff's anxiety was evidenced by recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror, and sense of impending doom occurring on the average of three times a month." (Tr. 392). Dr. Davis also stated:

> Activities of daily living include independent self-care, but rarely doing personal laundry, changing sheets, vacuuming, taking out the trash, or home repairs. He does prepare simple meals at home, including frozen pizza, macaroni and cheese, and hotdogs. He does pick up his prescriptions from a drugstore. He is independent for Dr. appointments, hair

> appointments, and support group. He drives and claims he can find his way around in unfamiliar areas. He takes care of his dog. Activities include playing cards, backgammon, pool, and computer games. Socially, he involves himself on a daily and weekly basis in family gatherings, support group, and pool. When on the job, he got along very well with others. Cognitively, he complains of difficulty focusing, only able to concentrate 30 to 60 minutes due to fatigue.

(Tr. 405-06). Dr. Davis determined the plaintiff's work-related limitation to be:

> mild to moderate difficulties maintaining attention and concentration for extended periods, which may interfere with more detailed tasks, especially if he is interrupted in the performance of the task. His work pace will also be moderately limited. No other limitations have been noted.

(Tr. 406).

On June 27, 2001, the plaintiff was seen by Dr. Viner for nausea and vomiting, as well as a lesion on his face. (Tr. 335). Dr. Viner noted that the plaintiff's weight was 254 and his physical examination was normal, except for the lesion caused by a herpes simplex eruption. (Tr. 335). He also stated, "I did not want to change the antiretroviral medication, but it is probably causing a few side effects." (Tr. 335).

On August 10, 2001, the plaintiff went to the Acute Care Center of the Medical Associates Clinic for a basic physical check-up following a car accident. (Tr. 420). Dr. Craig C. Schultz determined that the plaintiff had mild cervical back muscle strain and gave him a pain medication prescription along with instructions to ice his back. (Tr. 420). On August 22, 2001, Dr. Schultz treated the plaintiff in the Acute Care Center for a second time; on this visit the plaintiff complained of congestion and postnasal drainage. (Tr. 419). Dr. Schultz determined that the plaintiff had sinobronchitis and prescribed medication for this. (Tr. 419).

On September 5, 2001, the plaintiff was seen by Dr. Viner primarily for asthma and respiratory related issues including clear sinus drainage, coughs producing green nodules form his lungs, and some heartburn. (Tr. 454). Dr. Viner noted that everything else checked out as unremarkable and that the plaintiff "infrequently has diarrhea and rarely

has any rectal bleeding." (Tr. 454). Dr. Viner stressed the necessity of smoking cessation to the plaintiff and prescribed atiretroviral medications, Prevacid, Marinol, Flonase and Singular. (Tr. 452-454). The plaintiff's weight was 257. (Tr. 454).

On November 13, 2001 the plaintiff was seen by Dr. Viner following a two-week discontinuation of his antiviral medication. (Tr. 449). The plaintiff was back on his medication at the time of the appointment. (Tr. 449). Dr. Viner noted that the plaintiff had a "'mono' like illness with fatigue, cold sweats, but no cough recently" which "may have been retroviral in nature." (Tr. 449). Dr. Viner stressed the necessity of staying consistent with antiretroviral medication, as well discontinuation of smoking. (Tr. 449). The plaintiff also reported to Dr. Viner that he had a new job as a waiter and that he "finds more muscle pain and exhaustion from this." (Tr. 449). The plaintiff's weight was 266. (Tr. 449).

On January 5, 2002, the plaintiff was seen by Dr. Craig Schultz after he fell on some ice. Dr. Schultz determined the plaintiff's injuries to be a right hip contusion, a probable knee contusion, and a questionable upper back contusion or strain after he fell on some ice. (Tr. 414). No medication was prescribed to the plaintiff, but a statement of work limitation was issued; it stated that the plaintiff could return to regular work duties on January 7, 2002. (Tr. 414, 439).

On January 23, 2002, the plaintiff was seen by Dr. Viner. (Tr. 445). Dr. Viner noted that the plaintiff "has been gaining weight," his "appetite is unusually good," and he is walking five to seven miles a day as a cable worker, which has caused him pains in his knees and back. (Tr. 444). The plaintiff's viral load was "favorable and below detection" and his CD4 count was "stable at 445." (Tr. 445). Dr. Viner also stated that "the patient is interested in disability but I would like him to go through his disability hearing before we decide about this, as he is currently still working." (Tr. 445).

The plaintiff testified at his hearing that between 1994 and February 2002 he was employed by approximately nine different employers as a telecommunications sales representative, a telecommunications engineer, word processor, a door-to-door and by-

appointment salesperson, a car salesperson, a waiter, and a door-to-door cable salesperson and installer. (Tr. 493-99). He further testified that he stopped working as a door-to-door cable salesperson because he "got sick several times," which caused him to miss work on more days than he actually worked. (Tr. 483-84). He testified that following his HIV diagnosis, the jobs he attempted to hold were ended, by him or his employers, as the result of his absences caused by sickness, specifically severe physical pain, fatigue, nausea, vomiting and diarrhea. (Tr. 493-99). The plaintiff further testified that "the worst of the [medications'] side effects are the nausea and vomiting followed with the secondary side effect of the diarrhea." (Tr. 499). He also testified that "the third worst would probably be the fatigue and pain -- muscle pain that goes along with any type of physical activity." (Tr. 499). He described the nausea as unpredictable with a sudden and severe onset. (Tr. 500). The plaintiff also stated that he has intense, painful cramping in the lower abdomen when he has diarrhea, which comes suddenly and severely at least five out of seven days weekly. (Tr. 501). The plaintiff further testified that he is often as tired or more tired when he wakes from nighttime sleep. (Tr. 502). He stated that if he is not battling an infection and does not take a sleep aid he sleeps "sometimes as little as four hours sometimes as much as twelve to fourteen hours." (Tr. 502). Additionally, the plaintiff testified that he was less fatigued when he stopped taking some of his antiretroviral medication during his employment as a waiter, but as a "consequence of that was the virus came back which is dangerous." (Tr. 503). In his testimony, the plaintiff also stated that his daily activities generally include grooming, watching television, and napping for one and a half to three hours followed by more television watching, or on good days, going to a friend's house to play cards or watch a movie. (Tr. 509-10, 503). In his testimony, the plaintiff indicated that he gets fatigued after carrying groceries from his mother's car and is exhausted after a half mile walk. (Tr. 511). He also stated that he "can't really go around [mold]" and that he continues to smoke "about a half a pack a day." (Tr. 507, 509).

The plaintiff's mother testified as well. She testified that her son had been living with her since November of 2000. (Tr. 513). Ms. Mullin testified that although the plaintiff does not wake before 10:00 a.m., "he's usually pretty tired" and he spends most of his time resting and watching television. (Tr. 513). She stated that the plaintiff cannot do laundry, cooking, or cleaning because "those are activities he's just not physically able to do." (Tr. 516). Ms. Mullin further testified that the plaintiff experiences diarrhea two to three times almost daily and that "if he needs to get to the bathroom there better not be anybody in his way. He has to go instantly. . ." (Tr. 514). She also testified that the plaintiff's "vomiting has not been as much recently as it has been in the past." (Tr. 514). Ms. Mullin stated that she observed that "at least one if not two days a week [the plaintiff is] not able to go in [to work]. He's just physically not strong enough or have enough energy to actually get to work and stay there and do the work." (Tr. 515).

On February 26, 2002, Dr. Viner completed a Physical Residual Functional Capacity Assessment for the plaintiff's impairments upon the request of the ALJ. He determined that the plaintiff was capable of lifting twenty pounds occasionally and ten pounds frequently, of standing, walking, and sitting for six hours in an eight-hour day, and of pushing or pulling without limitation. (Tr. 465-66). Dr. Viner further determined that the plaintiff could occasionally climb, balance, stoop, kneel, crouch, and crawl. (Tr. 466). Dr. Viner indicated that the plaintiff is limited to reaching occasionally, but he has no other manipulative limitations; he also indicated that the plaintiff has no visual or communicative limitations. (Tr. 308-09). Dr. Viner determined that the plaintiff should avoid concentrated exposure to dust and fumes, odors, chemicals and gases; however, exposure to temperature extremes, noise, vibration, humidity/wetness, and hazards are unlimited. (Tr. 309).

Conclusions of Law

Scope of Review

In order for the court to affirm the ALJ's findings of fact, those findings must be supported by substantial evidence appearing in the record as a whole. See Lochner v. Sullivan, 968 F.2d 725, 727 (8th Cir. 1992); Cruse v. Bowen, 867 F.2d 1183, 1184 (8th Cir. 1989). Substantial evidence is more than a mere scintilla. It means relevant evidence a reasonable mind might accept as adequate to support a conclusion. Richardson v. Perales, 402 U.S. 389, 401 (1997); Cruse, 867 F.2d at 1184; Hall v. Bowen, 830 F.2d 906, 911 (8th Cir. 1987). Substantial evidence requires "something less than the weight of the evidence, and the possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's findings from being supported by substantial evidence." Cruse, 867 F.2d at 1184 (quoting Consolo v. Federal Maritime Comm'n, 383 U.S. 607, 620 (1966). The court must consider the weight of the evidence appearing in the record and apply a balancing test to contradictory evidence. Gunnels v. Bowen, 867 F.2d 1121, 1124 (8th Cir. 1989); Gavin v. Heckler, 811 F.2d 1195, 1199 (8th Cir. 1987).

ALJ's Determination of Disability

Determining whether a claimant is disabled is evaluated by a five-step process. See 20 C.F.R. § 404.1520(a)-(f); Bowen v. Yuckert, 482 U.S. 137, 140 (1987).

> The five steps are:
>
> (1) If the claimant is engaged in substantial gainful activity, disability benefits are denied.
> (2) If the claimant is not engaged in substantial gainful activity, her medical condition is evaluated to determine whether her impairment, or combination of impairments, is medically severe. If the impairment is not severe, benefits are denied.
> (3) If the impairment is severe, it is compared with the listed impairments the Secretary acknowledges as precluding substantial gainful activity. If the impairment is equivalent to one of the listed impairments, the claimant is disabled.

(4) If there is no conclusive determination of severe impairment, then the Secretary determines whether the claimant is prevented from performing the work she performed in the past. If the claimant is able to perform her previous work, she is not disabled.

(5) If the claimant cannot do her previous work, the Secretary must determine whether she is able to perform other work in the national economy given her age, education, and work experience.

Trenary v. Bowen, 898 F.2d 1361, 1364 n.3 (8th Cir. 1990) (citing Bowen v. Yuckert, 482 U.S. at 140-42); 20 C.F.R. § 404.1520(a)-(f).

"To establish a disability claim, the claimant bears the initial burden of proof to show that he is unable to perform his past relevant work." Frankl v. Shalala, 47 F.3d 935, 937 (8th Cir. 1995) (citing Reed v. Sullivan, 988 F.3d 812, 815 (8th Cir. 1993)). If the claimant meets the burden, the burden of proof then shifts to the Commissioner to demonstrate that the claimant retains the physical residual functional capacity (RFC) to perform a significant number of other jobs in the national economy that are consistent with the claimant's impairments and vocational factors such as age, education, and work experience. Id.

Under the first step of analysis the ALJ determined that the plaintiff had not engaged in substantial gainful activity since November 6, 2000. At the second step, the ALJ found that the plaintiff had the following impairments: HIV positive, chronic asthma due to allergies, and major depression, recurrent. At the third step, the ALJ determined that the plaintiff's impairments or combination of impairments were sever, but were not equivalent to one of the listed impairments. At the fourth step the ALJ determined that the plaintiff had the following RFC:

> to perform the exertional and nonexertional requirements of work except for lifting and carrying more than ten pounds maximum. He cannot perform repetitive lifting or carrying, and cannot do prolonged walking or climbing. He can only occasionally bend, squat, stoop, and crawl, and cannot be exposed to damp, moldy areas or in environments with high pollen levels, smoke, and chemicals. He cannot perform fast-

> paced work, and cannot work in positions requiring deadlines. He cannot work in positions with unusual stress, emergency situations, handling consumer or customer problems, or requiring similar intense interaction with others.

The ALJ determined that the plaintiff is unable to perform his past relevant work as a sales/marketing representative in telecommunications and as a telephone sales representative. The ALJ determined that the plaintiff retains the capacity to work other jobs, such as a final assembler, an addressor, and a touch up screener. Therefore, the ALJ denied benefits.

Opinion of Treating Physician

"A treating physician's opinion should not ordinarily be disregarded and is entitled to substantial weight. A treating physician's opinion regarding an applicant's impairment will be granted controlling weight, provided the opinion is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the record." Singh v. Apfel, 222 F.3d 448, 452 (8th Cir. 2000) (citation omitted). The regulations require the ALJ to give reasons for giving weight to or rejecting the statements of a treating physician. See 20 C.F.R. § 404.1527(d)(2). "The ALJ may discount or disregard such an opinion if other medical assessments are supported by superior medical evidence, or if the treating physician has offered inconsistent opinions." Hogan v. Apfel, 239 F.3d 958, 961 (8th Cir. 2001).

The plaintiff argues that the ALJ improperly rejected the opinions of his treating specialists, Dr. David Strike and Dr. John P. Viner. Specifically, the plaintiff argues that the ALJ, without giving specific, legitimate reasons, rejected or discredited Dr. Strike's assessment that the plaintiff could not manage the stress of full-time employment; Dr. Viner's assessment that the plaintiff experiences chronic diarrhea four to six times a day, and three or more episodes of night sweats per year with each episode lasting two weeks which worsens when attempts to work are made; and Dr. Viner's assessment that the plaintiff could reach only on an occasional basis. The plaintiff further argues that the

ALJ's findings ignored Dr. Strike's and Dr. Viner's notations of the plaintiff's stress, nausea, vomiting and fatigue throughout the medical records.

The ALJ discounted Dr. Strikes's opinion by stating:

> This assessment does not preclude all work activity, and was not consistent with the claimant's statement to Dr. Mahr that he was too busy to see a psychiatrist and did not need ongoing therapy. Dr. Strike's specialty is in infectious diseases, and not psychiatry or psychology. The claimant has not received ongoing treatment from a mental health professional since 1999. Therefore the undersigned gives very little weight to Dr. Strike's opinion that the claimant is unable to perform full-time employment because it is not consistent with the objective evidence of record.

While it was expected of Dr. Strike to be familiar with the plaintiff's stress levels for HIV treatment purposes, the ALJ was correct to conclude that it does not follow that he was qualified to assess how that stress affected the plaintiff's ability to work. A mental health professional is the most qualified individual to make this assessment and the plaintiff has refused to seek ongoing mental health treatment since August of 1999. The plaintiff continued to refuse such treatment even when both Dr. Strike and Dr. Mahr repeatedly encouraged him to see a psychiatrist in the fall of 2000. Additionally, the plaintiff made no specific reports of stress, anxiety, panic attacks, or sleep disturbances after August of 2000 until March of 2001 during a psychiatric evaluation with Dr. George M. Harper, which was completed at the referral of the State of Iowa's Disability Determination Services Bureau. Therefore, this court finds that the ALJ properly discredited Dr. Strike's opinion that the plaintiff could not manage the stress of full-time employment.

The ALJ rejected Dr. Viner's assessment by stating that "the assessment was not consistent with his own office notes or the objective evidence on record. Although there were several times when the claimant complained of diarrhea, there were also office visits that he reported bowel movements were not a problem." Although the ALJ's reasons for rejecting Dr. Viner's assessments could have been explained more adequately, it is clear that the record does not substantially support Dr. Viner's assessments. The record

indicates that during 1999 and 2001 the plaintiff only reported night sweats and weakness twice during each year and that he did not report any in 2000. Arguably, the record does support Dr. Viner's assessment of the plaintiff's diarrhea when considering the fact that his diarrhea returned and required additional medical attention after each period of improvement. However, the medical attention that was required was usually nothing more than medication adjustments. Furthermore, in February of 2002, Dr. Viner completed an RFC and determined that the plaintiff was capable of performing light work. Therefore, the court finds that the ALJ properly rejected Dr. Viner's assessments regarding the plaintiff's HIV manifestations.

Finally, it is also clear that the ALJ did not include Dr. Viner's limitation on the plaintiff's ability to reach in the hypothetical he posed to the vocational expert at the plaintiff's hearing. However, Dr. Viner's assessment is not supported in the RFC report he prepared or by the record as a whole. The record reflects that the plaintiff was seen for two shoulder injuries. In June of 1999, it was determined that the plaintiff had a left shoulder rotator cuff contusion and sprain that required physical therapy. However, no physical therapy is documented in the record. In March of 2001, it was determined that an x-ray taken of the plaintiff's right shoulder was normal but probably sprained and the plaintiff was issued a work limitation that stated he could return to work in two days. There is no additional documentation of injuries, pain, or discomfort in the plaintiff's shoulders. Therefore, the court finds that the ALJ properly disregarded Dr. Viner's assessment of the plaintiff's reaching limitation.

Subjective Allegations of Pain

The plaintiff argues that the ALJ improperly rejected his subjective complaints of pain. When evaluating the credibility of a claimant's subjective complaints, the ALJ may not disregard them "solely because the objective medical evidence does not fully support them." Polaski v. Heckler, 739 F.2d 1320, 1322 (8th Cir. 1984). "The [ALJ] is not free to accept or reject the claimant's subjective solely on the basis of personal observations. Subjective complaints may be discounted if there are inconsistencies in the evidence as a

whole." Id. In evaluating claimant's subjective impairment, the following factors are considered: (1) the applicant's daily activities; (2) the duration, frequency and intensity of pain; (3) precipitating and aggravating factors; (4) dosage, effectiveness and side effects of medication; and (5) functional restrictions. Id. at 1321-22. Subjective complaints may be discounted if inconsistencies exist in the evidence as a whole. Hinchey v. Shalala, 29 F.3d 428, 432 (8th Cir. 1994); Woolf v. Shalala, 3 F.3d 1210, 1213 (8th Cir. 1993).

The ALJ found the plaintiff's and his mother's testimony regarding his subjective allegations of pain and permanent disability to be "less than credible." While all of the ALJ's stated reasons for discrediting their testimony are not completely founded, several reasons do justify his decision. For example, inconsistent information regarding the distance that the plaintiff is able to walk and many of the plaintiff's daily activities, such as occasional laundry, light cooking, walking his dog, driving to the bank, doctor's appointments, and support group, and playing pool, cards, and darts with friends, do not support the plaintiff's allegations of weakness and fatigue to the point of permanent disability. Additionally, the plaintiff's non-compliance with his medication regimen draws their credibility into question. The record reflects numerous occasions upon which the plaintiff did not take his medication and the minimum of a two-week period in 2001 that the plaintiff intentionally stopped taking his medication. To claim permanent disability based upon HIV and its side effects, while carelessly, and at times intentionally, disobeying doctor's orders is not consistent. Therefore, the court finds that the ALJ properly discounted the plaintiff's and his mother's testimony regarding subjective allegations of pain and permanent disability.

Upon the foregoing,

IT IS ORDERED, that the court finds in favor of the defendant and the matter is dismissed.

June 15, 2004.

JOHN A. JARVEY
Magistrate Judge
UNITED STATES DISTRICT COURT